EXISTING PATIENT DOCUMENTS

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PATIENT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Emergency Contact: _____ Phone: _____

Pharmacy Name and Phone Number: _____

☐ Male ☐ Female Referred By: _____

PRIMARY INSURANCE

Insurance Company: _____ ID #: _____

Group #: _____ Subscriber #: _____

Name on Account: _____ Relation: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ Zip: _____

ADDITIONAL INSURANCE

Insurance Company: _____ ID #: _____

Group #: _____ Subscriber #: _____

Name on Account: _____ Relation: _____

Date of Birth: _____ Phone: _____

Address: _____ City: _____ Zip: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to Dr. Raymond Shaheen all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ **DATE:** _____

GENERAL HEALTH QUESTIONNAIRE

Primary Doctor:_____ **Phone:**_____

1. Any new complaints or symptoms? If so, please list:

□_____ □_____
□_____ □_____

2. Any change in medications or taking new medications? If so, please list:

□_____ □_____
□_____ □_____

3. Please state if you've had any recent surgeries, and if so please provide the type and date of surgery:

□_____ □_____

4. Do you have any new allergies? If so, please list:

□_____ □_____

5. Social History:

□ Alcohol Duration/Amount/Frequency:_____
□ Smoking Duration/Amount/Frequency:_____
□ Other (specify): _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice takes effect on your first date of service and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the charges.

Notice of change to privacy practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians and medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in caring for you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Printed Name:_____ Date of Birth:_____

Signature:_____Date:_____